How Maternal Safety Bundles Save Lives

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Executive Director, Institute for Perinatal Quality Improvement

Disclosures

Debra Bingham is the Executive Director of the Institute for Perinatal Quality Improvement and is a consultant for the:

- National Perinatal Information Center
- Association of Women's Health, Obstetric and Neonatal Nurses.

- I will not discuss any off-label use/or investigational use in my presentation.

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17 Year Research to Action Gap

"It now takes an average of 17 years for new knowledge generated by randomized controlled trials to be incorporated into practice, and even then application is highly uneven."

Institute of Medicine (2001). Crossing the quality chasm: A new health system for the 21st Century, pg. 5.

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The mission of the Institute for Perinatal Quality Improvement (PQI) is to **expand the use of improvement science** in order to eliminate preventable perinatal morbidity and mortality and end perinatal racial and ethnic disparities.

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After participation in this presentation, you should have an increased knowledge and enhanced competence to…

1) Describe why the maternal safety bundles are needed.

2) Outline the key recommendations in changing practices and tips to implement these changes.

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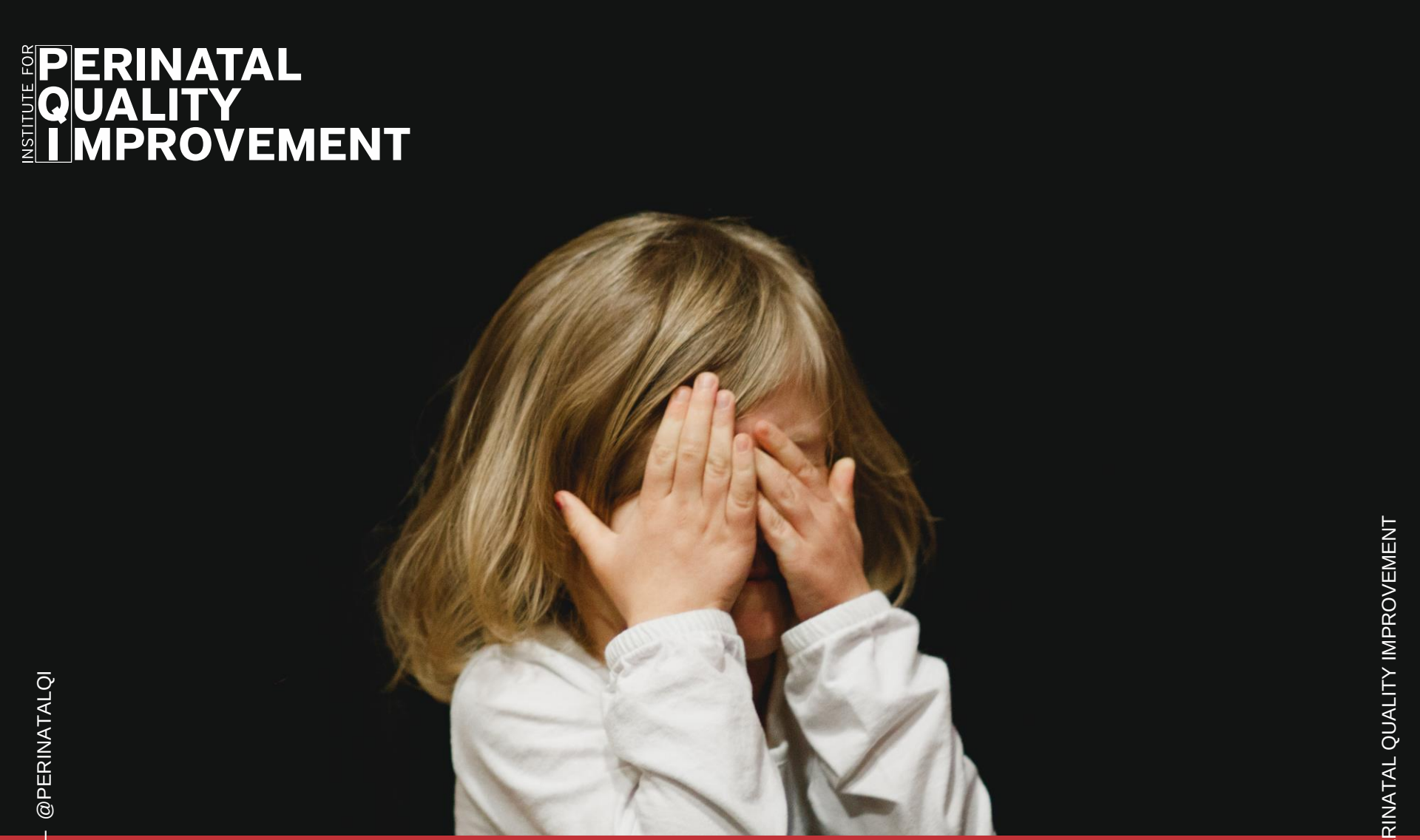

Don’t be afraid to look at your QI data.

Data helps us know what improvements are needed.

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Trends in Maternal Morbidity and Mortality
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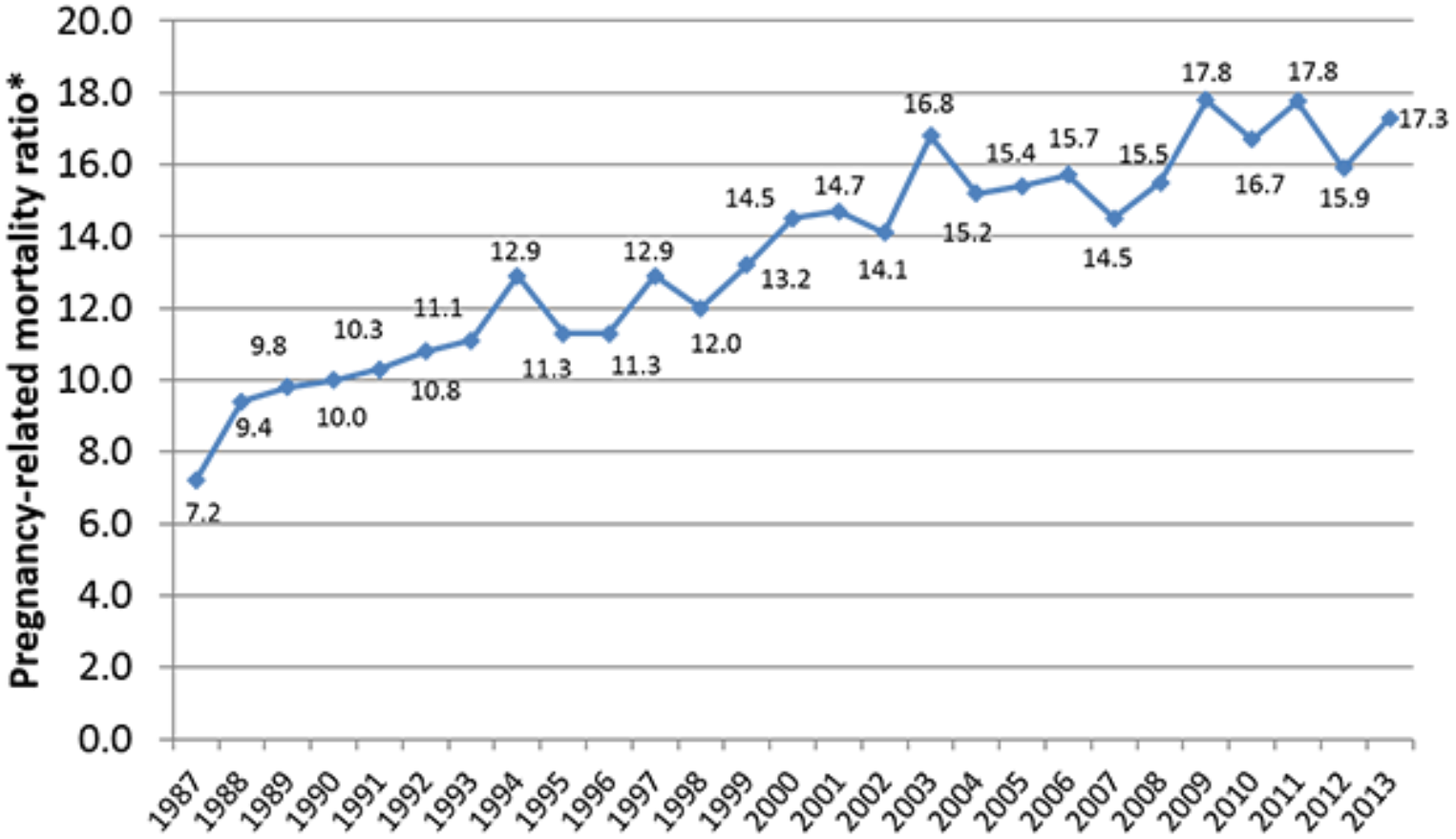
Trends in pregnancy-related mortality in the United States: 1987–2013



*Note: Number of pregnancy-related deaths per 100,000 live births per year.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm

Original Research

Recent Increases in the U.S. Maternal Mortality Rate

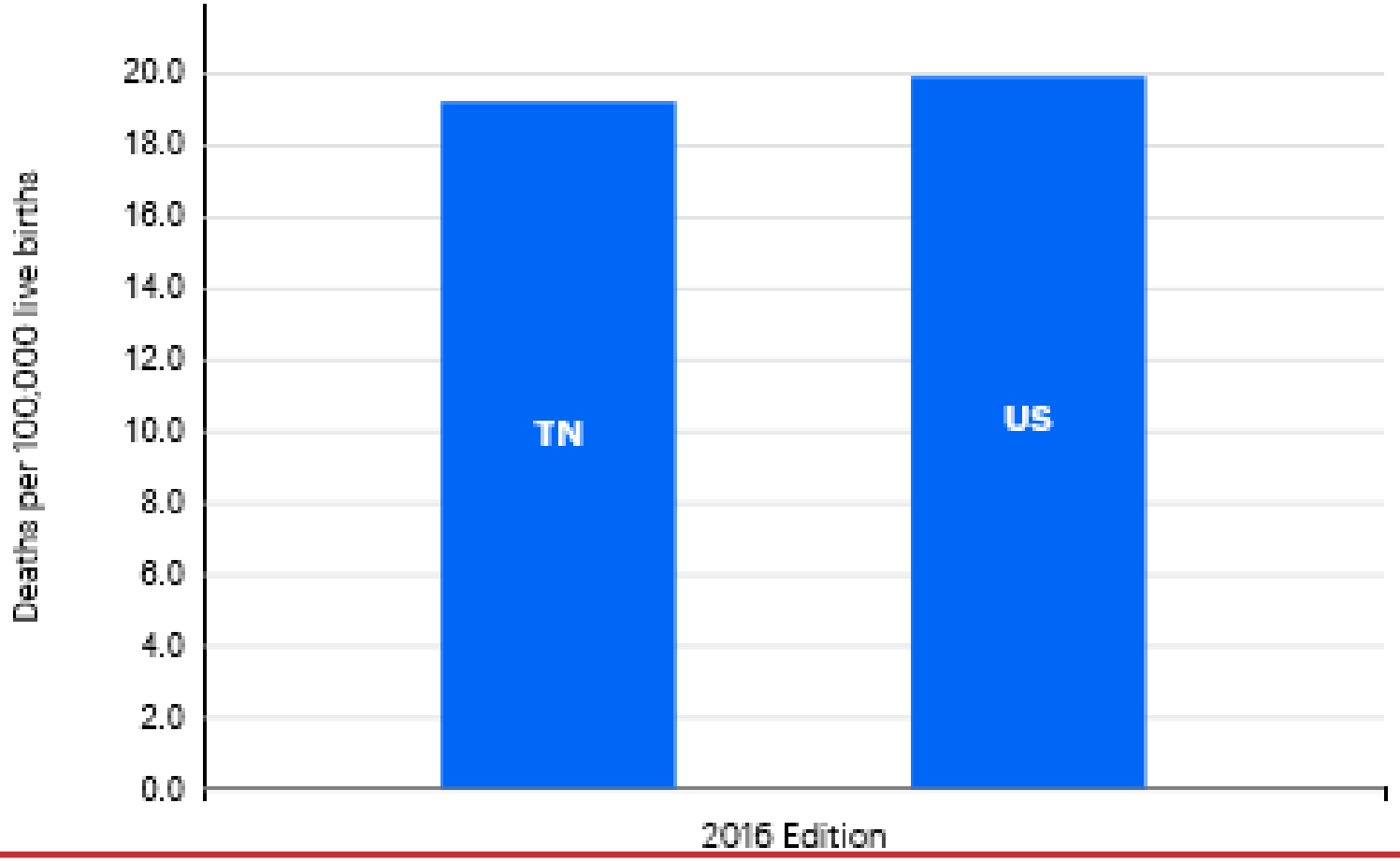
Disentangling Trends From Measurement Issues

Marian F. MacDorman, PhD, Eugene Declercq, PhD, Howard Cabral, PhD, and Christine Morton, PhD

"Simply totaling the raw, unadjusted data from all states results in a reported U.S. maternal mortality rate that more than doubled from **9.8** maternal deaths per 100,000 live births in 2000 to 21.5 deaths per 100,000 live births in 2014."

MacDorman, M.F., Declercq, E., Cabral, H., and Morton, C. (2016). Recent increases in the U.S. maternal mortality rate. Obstetrics & Gynecology.

America's Health Rankings



https://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/maternal_mortality/state/TN/

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The Leading Causes of Pregnancy-Related Mortality

Causes of deaths has shifted over time. Currently in the United States the leading causes of the 2011-2013 deaths are:

- Cardiovascular diseases, 15.5%.
- Non-cardiovascular diseases, 14.5%.
- Infection or sepsis, 12.7%.
- Hemorrhage, 11.4%.
- Cardiomyopathy, 11.0%.
- Thrombotic pulmonary embolism, 9.2%.
- Hypertensive disorders of pregnancy, 7.4%.
- Cerebrovascular accidents, 6.6%.
- Amniotic fluid embolism, 5.5%.
- Anesthesia complications, 0.2%.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm

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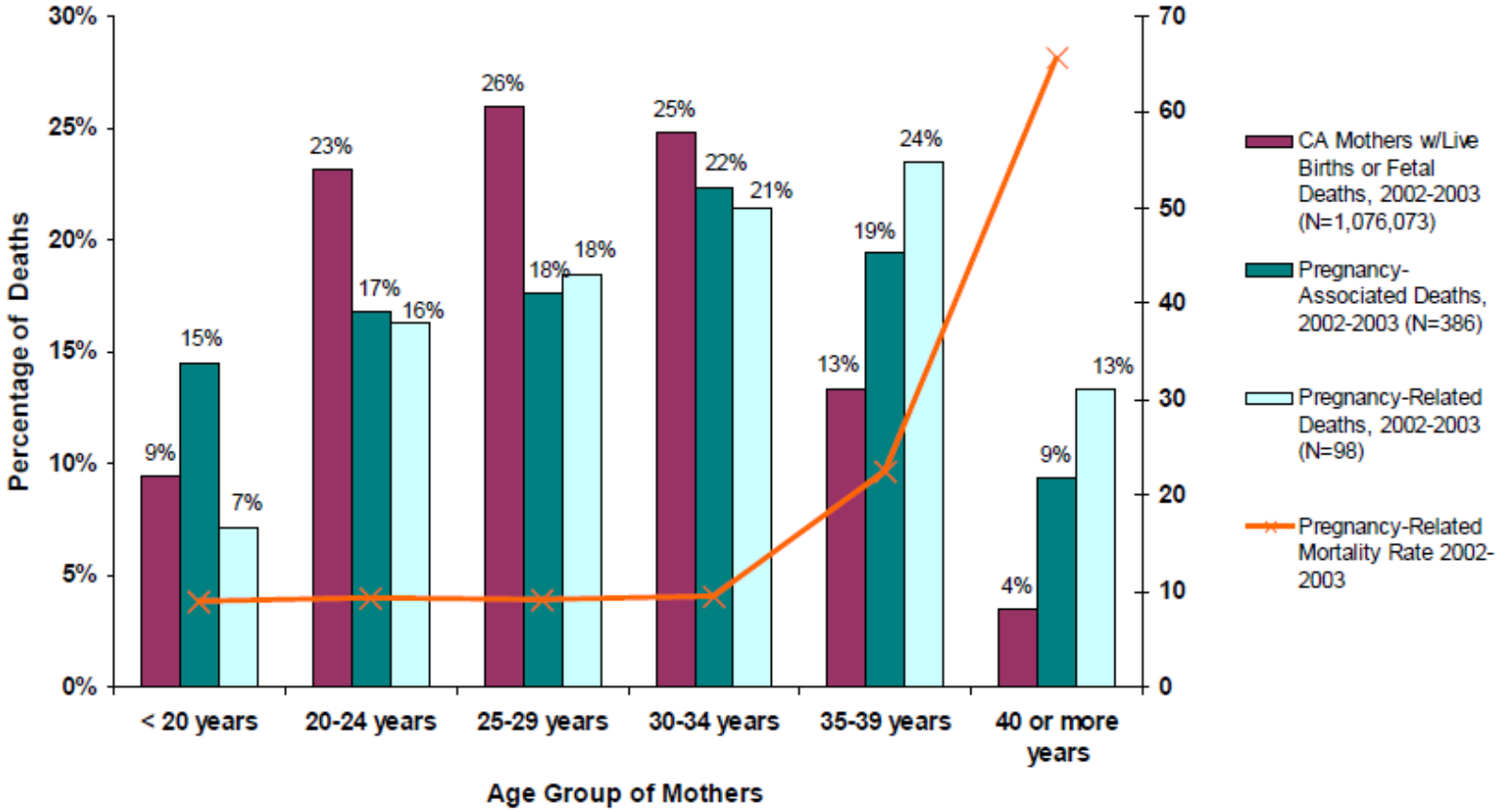
We Need System, Clinical, and Population Health Strategies

Age of Mother at Death and Pregnancy-Related Deaths Rates, California; 2002-2003



California Department of Public Health (2011). The California pregnancy associated mortality review: Report from 2002 and 2003 Maternal Death Reviews. Pg. 27.

Lessons Learned from

- Hemorrhagic death
  - 93% of all deaths were potentially preventable
  - Lack of appropriate attention to clinical signs of hemorrhage
  - Failure to restore blood volume, to act decisively with life saving interventions
- Severe Hypertension
  - 60% of maternal deaths were potentially preventable
  - Failure to control blood pressure, to recognize HELLP syndrome, to diagnosis and treat pulmonary edema
- Pulmonary Embolism
  - “single cause of death most amenable to reduction by systematic change in practice”
  - Failure to use adequate prophylaxis

Berg CJ, et al. Obstet Gynecol 2005;106:1228-34;
Cantwell R, et al. BJOG 2011 Mar;118 Suppl 1:1-203;
Clark, SL. Semin Perinatol 2012;36(1):42-7

In the United States Racial Disparities Persist

- 12.7 deaths per 100,000 live births for white women.
- 43.5 deaths per 100,000 live births for black women.
- 14.4 deaths per 100,000 live births for women of other races.

Much of these disparities are due to structural racism

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.htm

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Maternal Mortality is the Tip of the Iceberg
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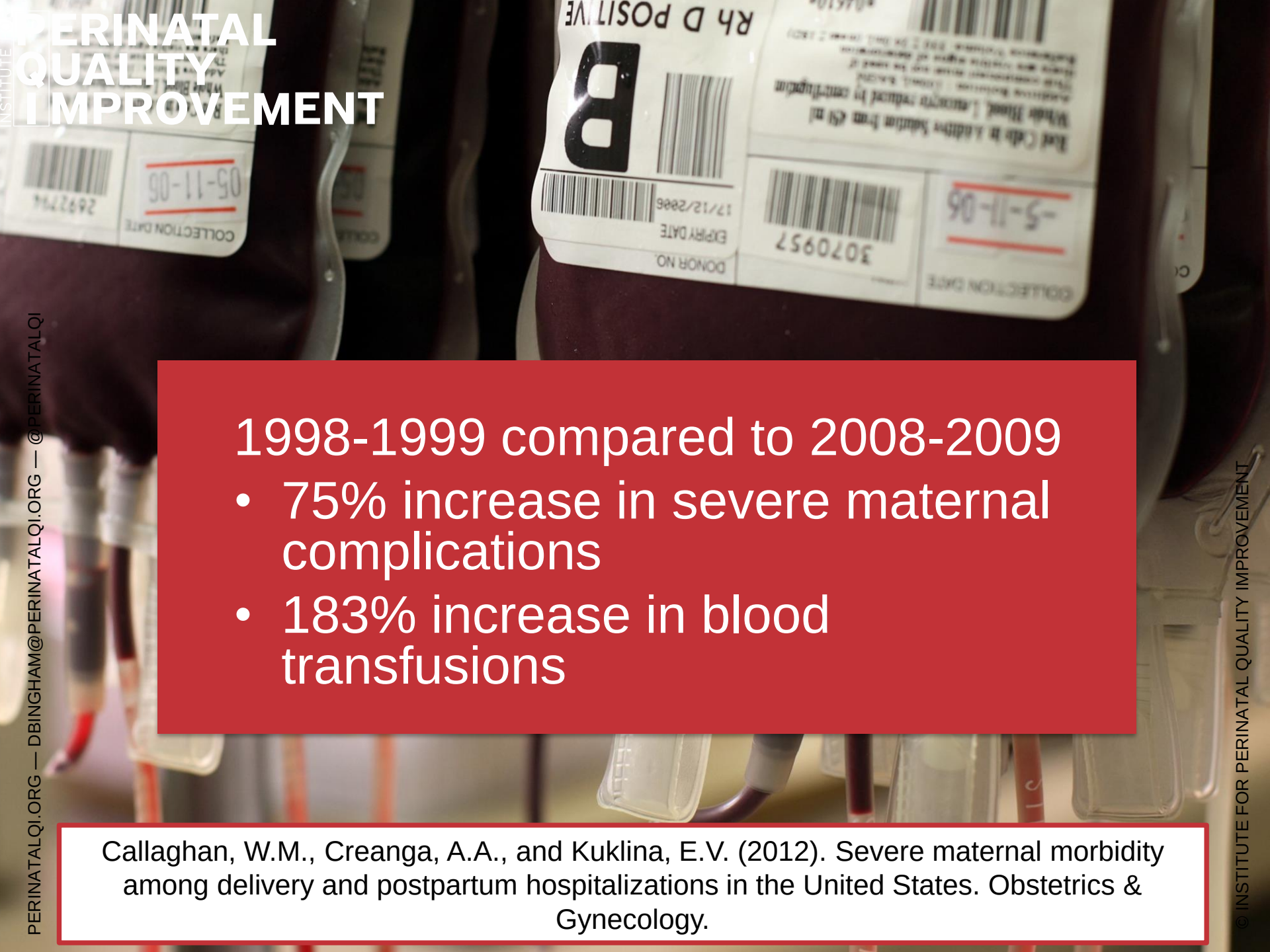

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1998-1999 compared to 2008-2009

- 75% increase in severe maternal complications
- 183% increase in blood transfusions

Callaghan, W.M., Creanga, A.A., and Kuklina, E.V. (2012). Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. Obstetrics & Gynecology.

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Secondary Trauma Reported

- 35% of the 464 labor and delivery nurse members of AWHONN who responded to a national survey reported moderate to severe levels of secondary traumatic stress

- Some reported that the stress was so severe they were considering no longer being L&D nurses

Beck, C.T. and Gable, R.K. (2012). A mixed methods study of secondary traumatic stress in labor and delivery nurses. Journal of Obstetric, Gynecologic & Neonatal Nursing. Pp. 1-14

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Women and newborns die or suffer injuries because they do not receive early, effective and aggressive lifesaving treatments.

California Department of Public Health (2011). The California pregnancy associated mortality review: Report from 2002 and 2003 Maternal Death Reviews. National Health Statistics.

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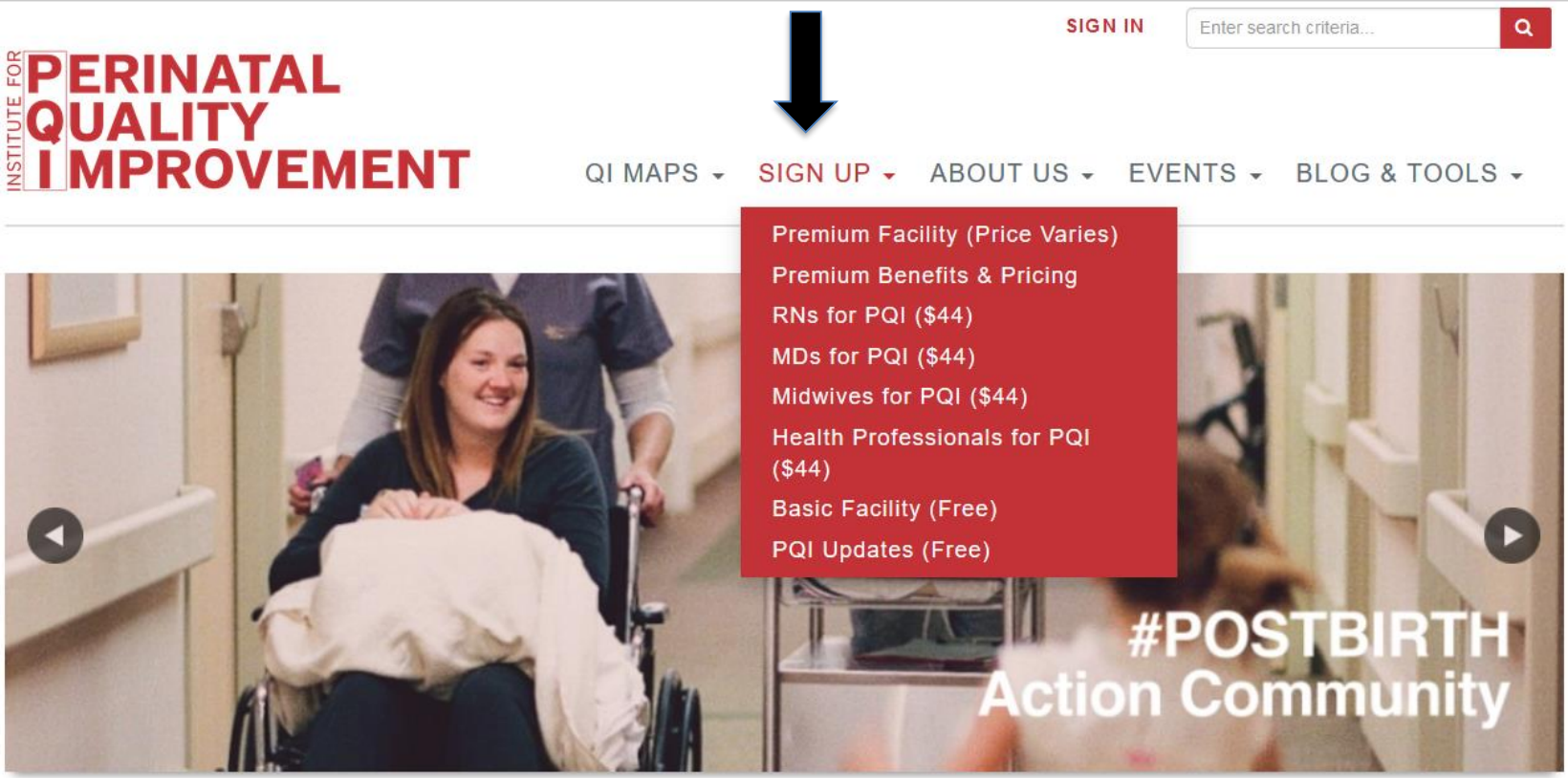

Definition of QI

"When we use the term "QI" in this report, we mean systematic, ***data-guided*** *activities designed to bring about immediate,* ***positive changes*** *in the delivery of health care in particular settings."*

Baily, M.A., Bottrell, M., Lynn, J., & Jennings (2006). Special report: the ethics of using QI methods to improve healthcare quality and safety. The Hastings Center: Garrison New York, pg. S5.

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Who has the responsibility for improving the quality of care?

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*"We conclude that engaging in quality improvement is **NOT** purely **Discretionary**; health professionals, managers, delivery organizations, patients, and government all have an ethical responsibility to cooperate with one another to improve the quality of care."*

Baily, M.A., Bottrell, M., Lynn, J., & Jennings (2006). Special report: the ethics of using QI methods to improve healthcare quality and safety. The Hastings Center: Garrison New York, pg. S6.

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Have you received education on QI concepts, methods, and tools?

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Clinicians need QI Education & QI Support

- QI Methods and Concepts
  - Implementation Frameworks
  - QI Process Models
  - QI Ethics
- QI Tools
  - Process Maps
  - Fishbone Diagrams
  - Logic Models
  - Driver Diagrams

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Implementing Perinatal Quality Improvement

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Conference on February 1, 2018, New York City


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Council on Patient Safety in Women's Health Care

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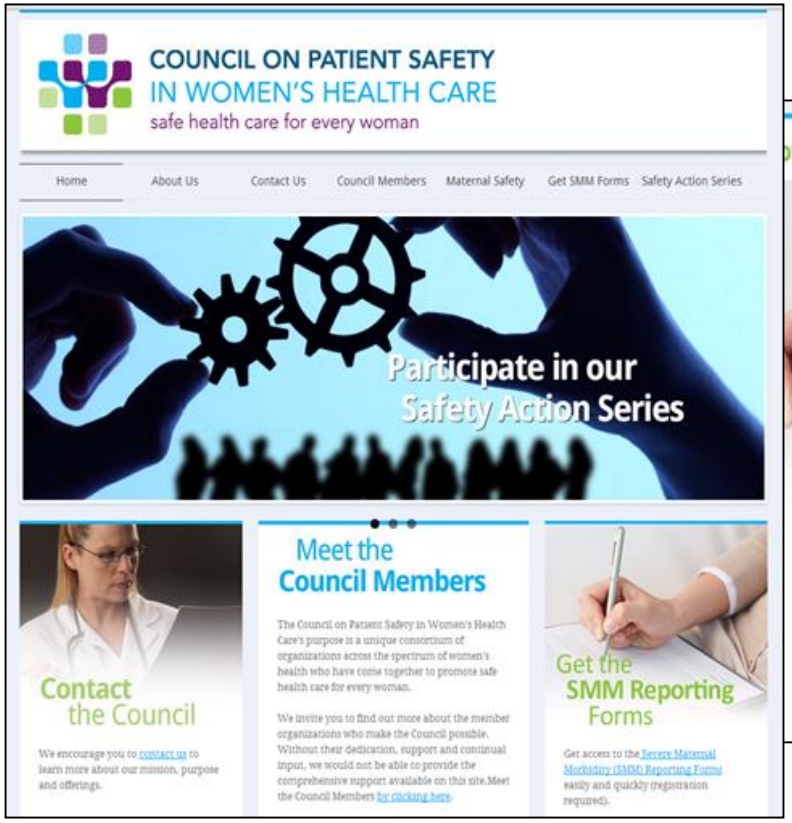

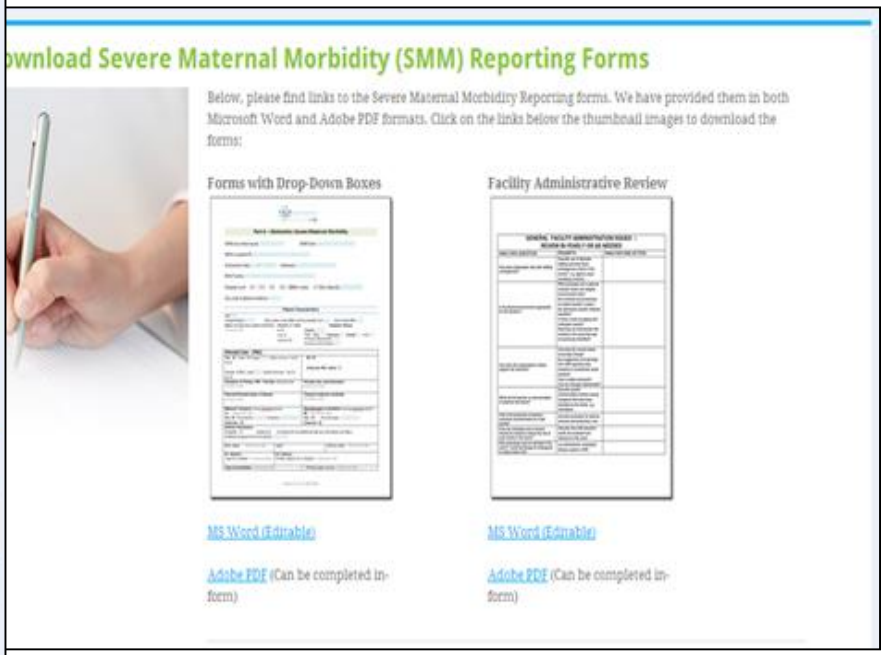

AANA · ABOG · AUGS · AWHONN · NPWH · PULSE of New York · SOAP

Dr. Bingham was the Vice Chair and Chair of the Council

Council on Patient Safety in Women's Health Care Bundles

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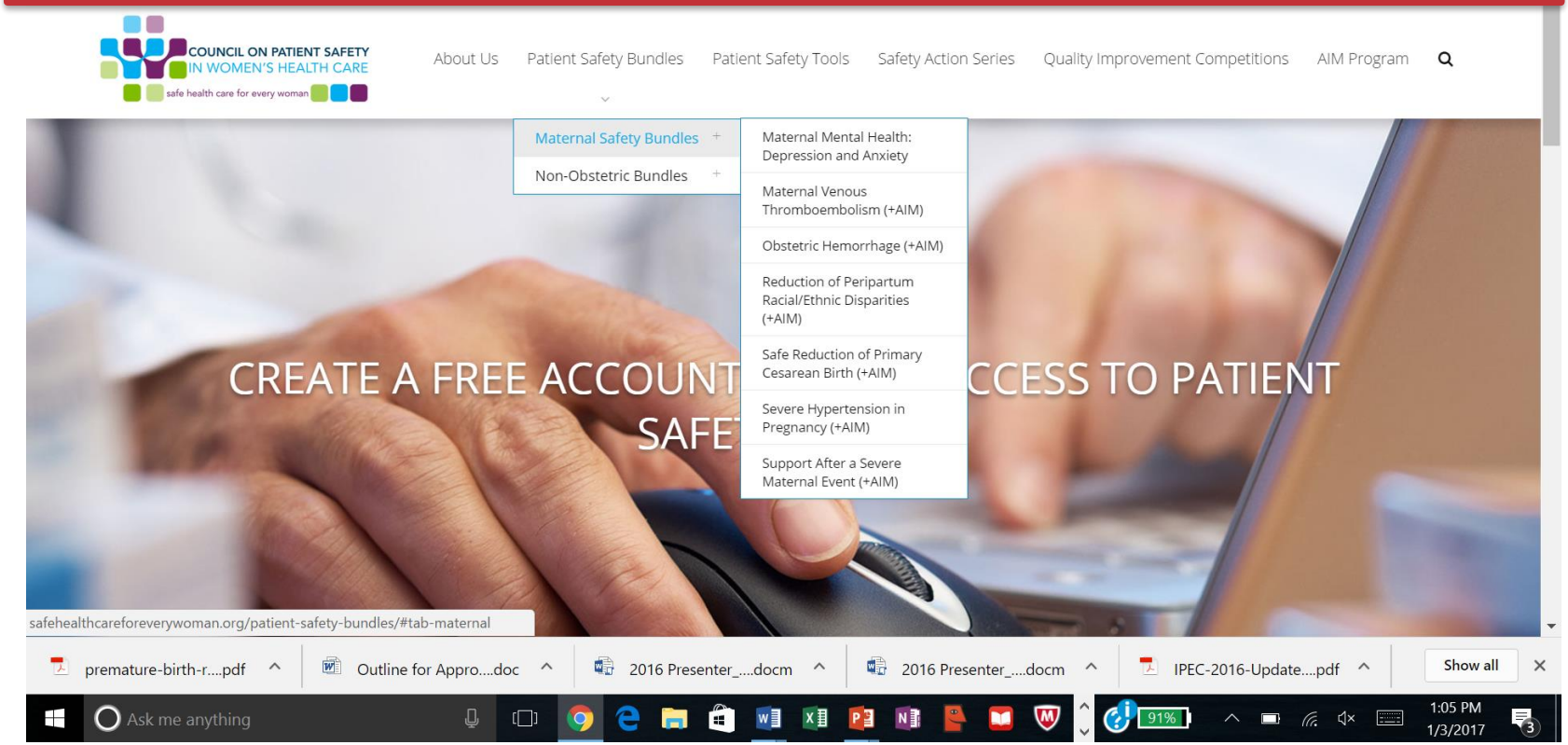

Maternal Bundles

- Maternal Mental Health: Depression and Anxiety
- Alliance on Maternal Health (AIM)
  - Safety Bundles
    - Obstetric Hemorrhage
    - Maternal Venous Thromboembolism
    - Severe Hypertension in Pregnancy
  - Safe Reduction of Primary Cesarean Birth
  - Support after a Severe Maternal Event
  - Reduction of Peripartum Racial/Ethnic Disparities

HRSA -- Alliance on Innovation in Maternal Health (AIM)

Priorities for AIM are:

- Reducing cesarean sections
- 3 safety bundles
  (Hemorrhage, Venous Thromboembolism, Hypertension)
- Preconception Care
- Reducing Disparities

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National Partnership for Patient Safety
Maternal Safety Bundles

"What every birthing facility in the U.S. should have…"

All Safety Bundles Include Recommendations to:

- Hold Team Huddles
- Debrief After Events
- Run Simulation Drills

"What every birthing facility in the U.S. should have…"

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EXPERT OPINION

Transforming Communication and Safety Culture in Intrapartum Care: A Multi-Organization Blueprint

Audrey Lyndon, M. Christina Johnson, Debra Bingham, Peter G. Napolitano, Gerald Joseph, David G. Maxfield, and Daniel F. O'Keeffe

JOGNN

EXPERT OPINION

Standardized Severe Maternal Morbidity Review: Rationale and Process

Sarah J. Kilpatrick, Cynthia Berg, Peter Bernstein, Debra Bingham, Ana Delgado, William M. Callaghan, Karen Harris, Susan Lanni, Jeanne Mahoney, Elliot Main, Amy Nacht, Michael Schellpfeffer, Thomas Westover, and Margaret Harper

JOGNN

EXPERT OPINION

National Partnership for Maternal Safety: Consensus Bundle on Obstetric Hemorrhage

Elliott K. Main, Dena Goffman, Barbara M. Scavone, Lisa Kane Low, Debra Bingham, Patricia L. Fontaine, Jed B. Gorlin, David C. Lagrew, and Barbara S. Levy

Co-Published in Journals for ACOG, ACNM, ASA, and AWHONN

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PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

Obstetric Hemorrhage Commentary

JOGNN

EXPERT OPINION

National Partnership for Maternal Safety: Consensus Bundle on Obstetric Hemorrhage

Elliott K. Main, Dena Goffman, Barbara M. Scavone, Lisa Kane Low, Debra Bingham, Patricia L. Fontaine, Jed B. Gorlin, David C. Lagrew, and Barbara S. Levy

Main, E.K., Goffman, D., Scavone, B.M., Low, L.K., Bingham, D., Gorlin, J.B., Lagrew, D.C., & Levy, B.S. (2015). National partnership for maternal safety: consensus bundle on hemorrhage. *Journal of Obstetric, Gynecologic, and Neonatal Nursing.* pp. 1-10.
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How front-line leaders can utilize the safety bundles
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Mobilize - Change Champions

Explain **WHY** the change is needed

- A committed leader will not give up

- A confident change champion feels they are up to the task and will keep trying

Weiner, B.J. (2009). A theory of organizational readiness for change. Implementation Science. Doi:10.1186/1748-5908-4-67

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FOCUS ON BEHAVIORS

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Safe Reduction of Primary Cesarean Births

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

RECOGNITION AND PREVENTION

Every patient

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

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Examples of Key Behaviors: Safe Reduction of Primary Cesarean Births

- Build a culture that values, promotes, and supports vaginal birth
- Ensure informed consent
- Provide labor support that maximizes the likelihood of vaginal birth
  - Reduce early admissions
  - Encourage freedom of movement in labor
  - Non-pharmacologic pain management
- Standardize induction scheduling to ensure proper selection and preparation of women undergoing induction
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity
- Offer breech version, instrumented delivery, and twin delivery
- Track cesarean birth statistics

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PATIENT SAFETY BUNDLE

Maternal Venous Thromboembolism Prevention

READINESS

Every Unit

- Use a standardized thromboembolism risk assessment tool for VTE during:
  - Outpatient prenatal care
  - Antepartum hospitalization
  - Hospitalization after cesarean or vaginal deliveries
  - Postpartum period (up to 6 weeks after delivery)

RECOGNITION & PREVENTION

Every Patient

- Apply standardized tool to all patients to assess VTE risk at time points designated under "Readiness"
- Apply standardized tool to identify appropriate patients for thromboprophylaxis
- Provide patient education
- Provide all healthcare providers education regarding risk assessment tools and recommended thromboprophylaxis

RESPONSE

Every Unit

- Use standardized recommendations for mechanical thromboprophylaxis
- Use standardized recommendations for dosing of prophylactic and therapeutic pharmacologic anticoagulation
- Use standardized recommendations for appropriate timing of pharmacologic prophylaxis with neuraxial anesthesia

REPORTING/SYSTEMS LEARNING

Every Unit

- Review all thromboembolism events for systems issues and compliance with protocols
- Monitor process metrics and outcomes in a standardized fashion
- Assess for complications of pharmacologic thromboprophylaxis

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Examples of Key Behaviors: Venous Thromboembolism Bundle

- Risk Assessments
  - Prenatal Care
  - Antepartum, Intrapartum, & Postpartum hospitalization
  - Postpartum (up to 6 weeks)
- Provide and Time Prophylaxis based on Risk and Plan of Care
    - Chemical and Mechanical

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PATIENT SAFETY BUNDLE

Hypertension

READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

RECOGNITION & PREVENTION

Every Patient

- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

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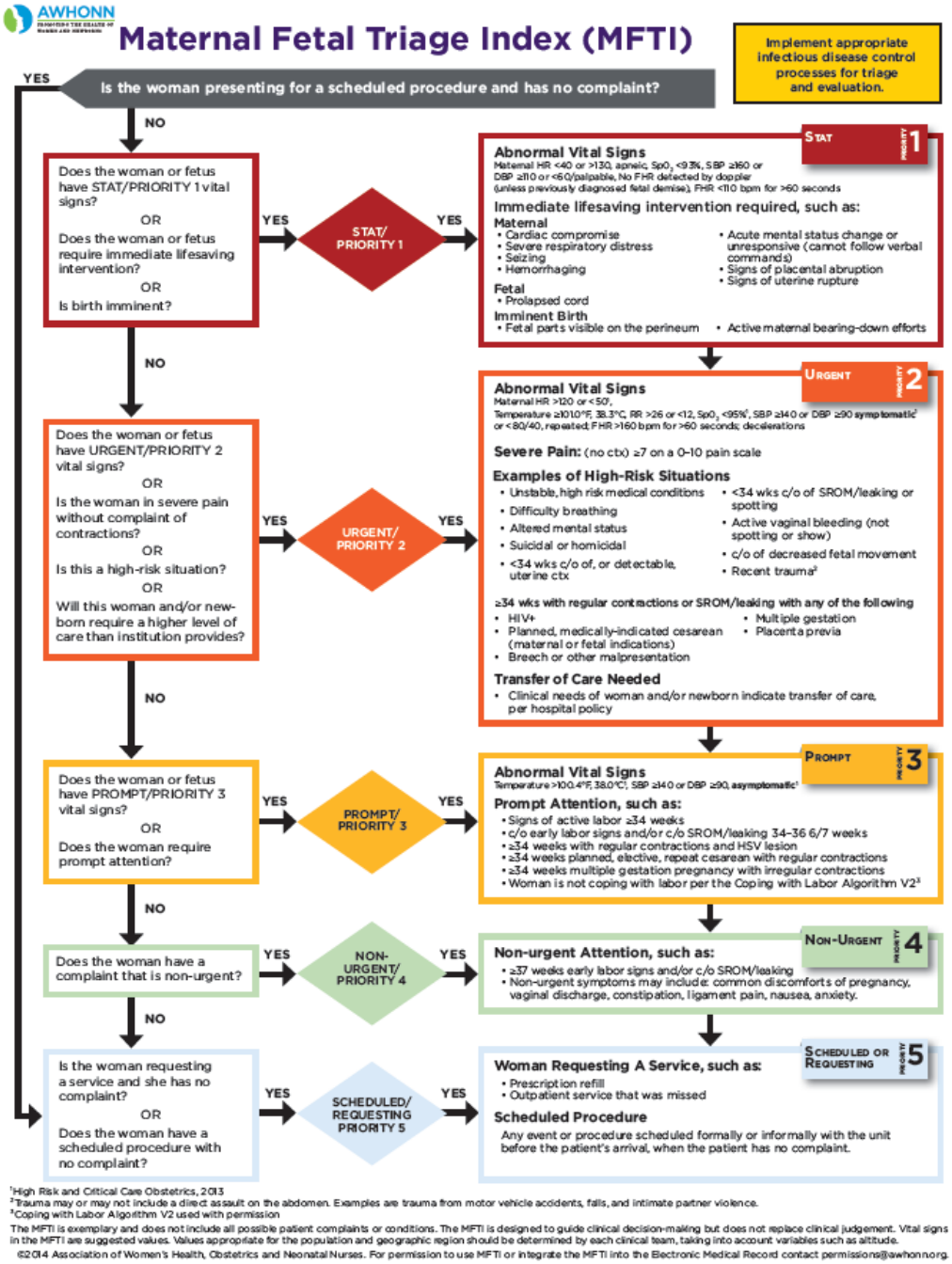
Examples of Key Behaviors: Hypertension Bundle

- Accurately Assess Blood Pressures
- Clear Diagnostic Guidelines with checklists based on blood pressure
- Timely Triage, evaluation, and treatment of pregnant and postpartum women
  - Labor and Delivery
  - Emergency Department
  - Outpatient areas



Ruhl, C., Scheich, B., Onokpise, B., and Bingham, D. (2015). Content validity testing of the maternal fetal triage index. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*. doi: 10.1111/1552-6909.12763

Ruhl, C., Scheich, B., Onokpise, B., and Bingham, D. (2015). Interrater reliability testing of the maternal fetal triage index. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*. doi: 10.1111/1552-6909.12762.

Minimum Requirements for the Hypertension Protocol

- Notify primary care provider if the systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
- After the 2nd elevated reading, treatment should be initiated ASAP (preferably within 60 minutes)
  - Magnesium sulfate
  - Add other medications if no response
  - Admit to ICU based on pre-defined criteria
  - Follow-up within 7 to 14 days postpartum
  - Provide postpartum patient education

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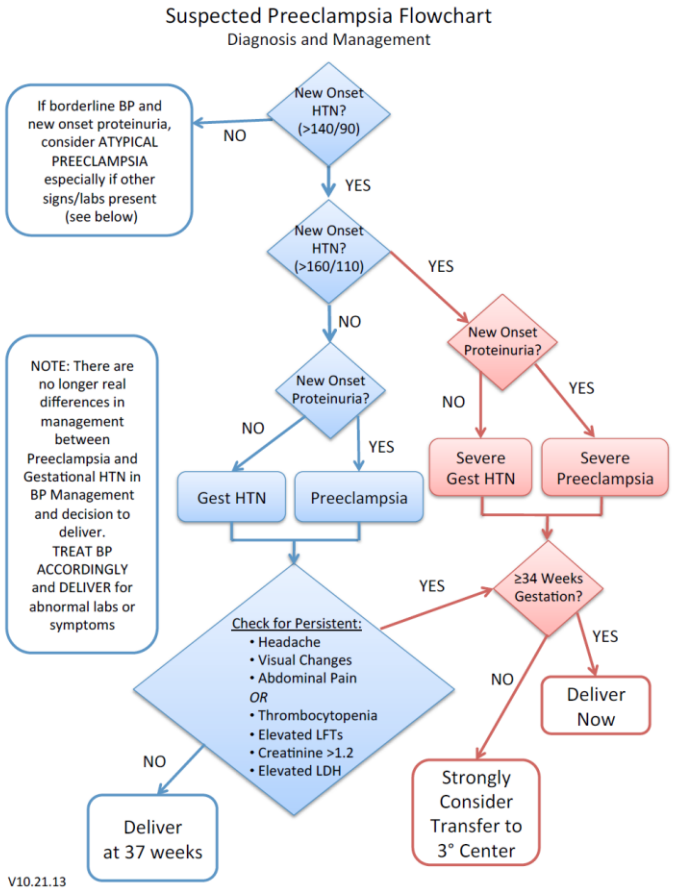
CMQCC CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

California Department of PublicHealth

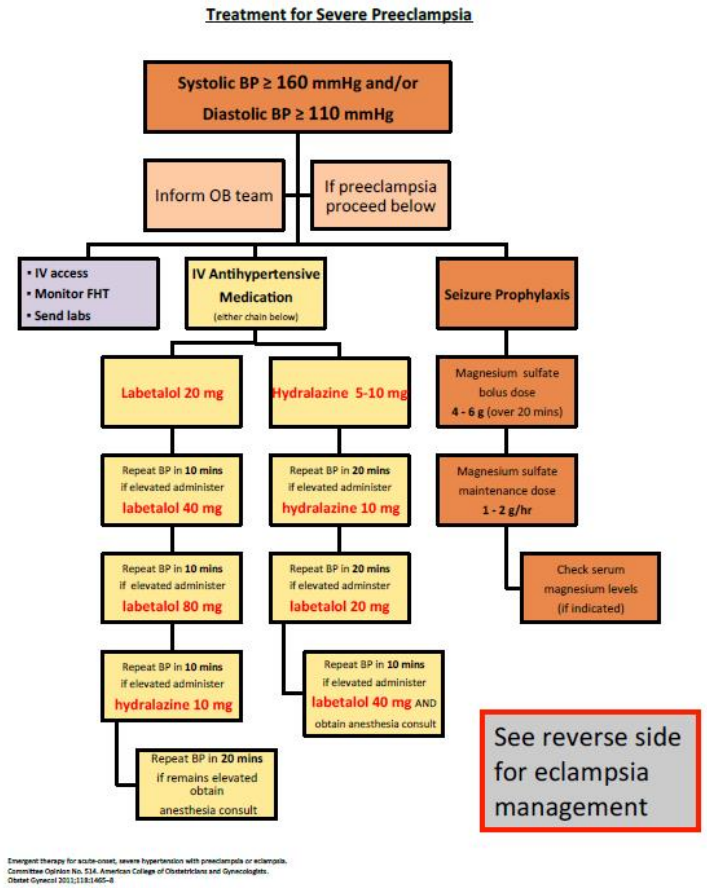
PREECLAMPSIA CARE GUIDELINES AND
CMQCC PREECLAMPSIA TOOLKIT
CDPH-MCAH Approved: 12/20/13

Appendix C: Suspected Preeclampsia Algorithm Diagnosis and Management



CMQCC Preeclampsia Care Guidelines and CMQCC Preeclampsia Toolkit. https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

Appendix B: Sample Treatment of Severe Preeclampsia Algorithm



Emergent therapy for acute-onset, severe hypertension with preeclampsia or eclampsia. Committee Opinion No. 514. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1465–8

CMQCC Preeclampsia Care Guidelines and CMQCC Preeclampsia Toolkit. https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

Preparing to Take a Blood Pressure

- Equipment:
  - Correct cuff size
  - Keep equipment in repair
- Position:
  - Sitting or semi-reclining position with back supported
  - Arm at heart level
  - Legs uncrossed
  - Feet on a flat surface, not dangling
- Patient sits quietly for 5 minutes before taking the blood pressure
- History
  - Intake of nicotine and caffeine in the past 30 minutes?
  - Do not delay treatment based on history

CMQCC Preeclampsia Care Guidelines and CMQCC Preeclampsia Toolkit. https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

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Taking an Accurate Blood Pressure

- Support the patient's arm at heart level
- Patient should be instructed not to talk
- Use first audible sound (Kortokoff I)
- Use disappearance of sound (Kortokoff V)
- Nearest 2 mmHg
- Use the highest reading
- If greater than or equal to 140/90, repeat in 15 minute. If still elevated evaluate for Preeclampsia

CMQCC Preeclampsia Care Guidelines and CMQCC Preeclampsia Toolkit. https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

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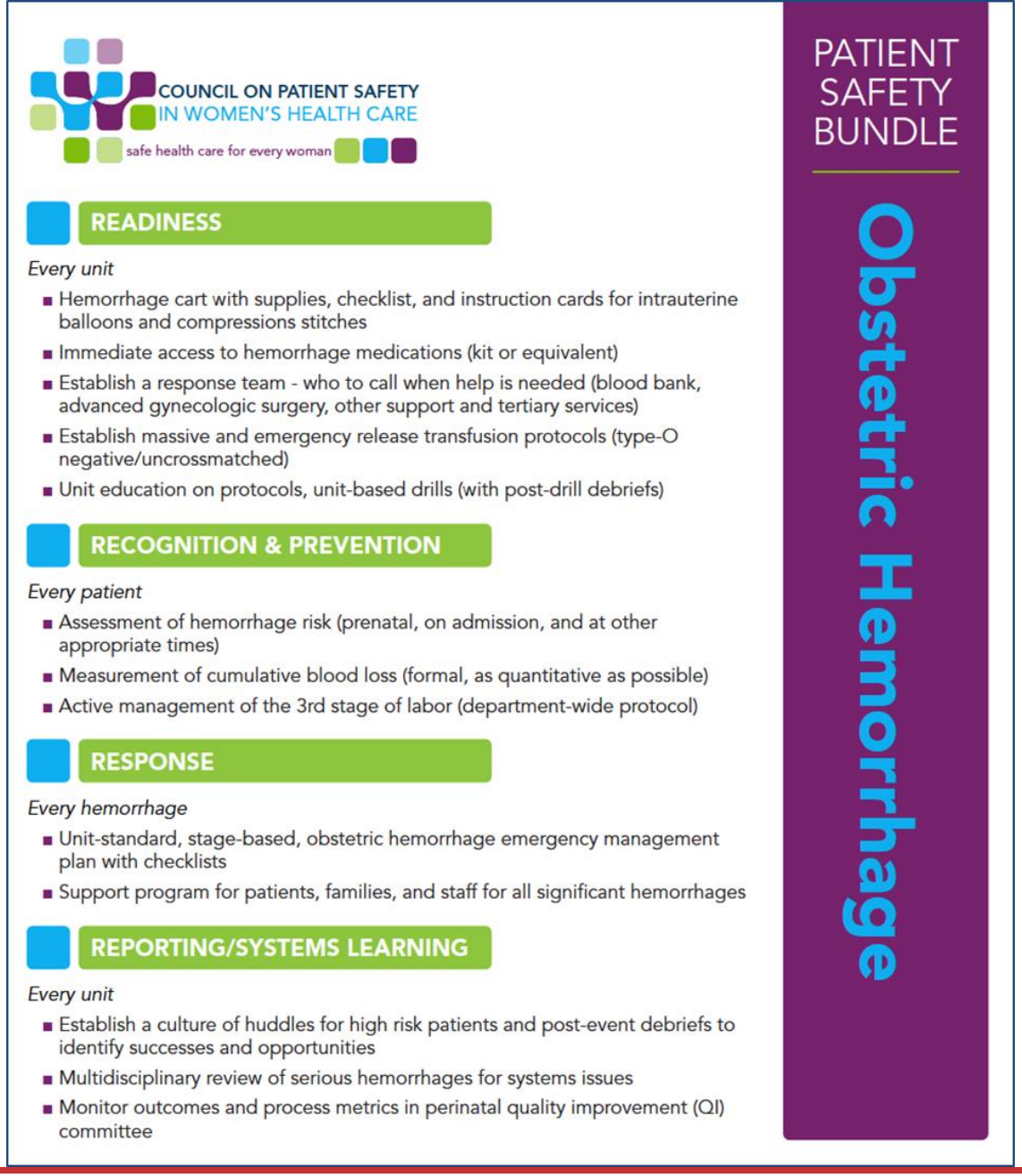

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Examples of Key Behaviors: Obstetric Hemorrhage Bundle

- Perform Risk Assessments on Prenatal, Admission, Pre-Birth, and Post-Birth
- Implement Quantification of Blood Loss
- Implement an obstetric hemorrhage algorithm based on blood loss
- Debrief after all Stage 2 and 3 hemorrhages
- Huddles for high-risk women
- Run Obstetric Simulation Drills

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Set A Goal
Quality Improvement Aim Statement

- By April 2018 the nurses and physicians at Fabulous Hospital will perform hemorrhage risk assessments on admission, pre-birth, and post-birth, quantify blood loss at every birth, use actual blood loss to determine actions, debrief, accurately take blood pressures, and administer anti-hypertensives within 60 min. if the B/P is 160/110.
- We will track our progress by….

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Track Progress

- Structure
  - Update policies and procedures
  - Simulation drills
  - Educate clinical team
- Process
  - Quantification of Blood loss
  - Risk Assessments
- Outcomes – with Balancing Measures
  - ICU admission
  - Blood transfusions
- Balancing Measures when indicated

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Quality Improvement is like climbing a spiral staircase

Each cycle gets you closer to your goal

Without data QI leaders can go around & around in a circle like a cat chasing her tail

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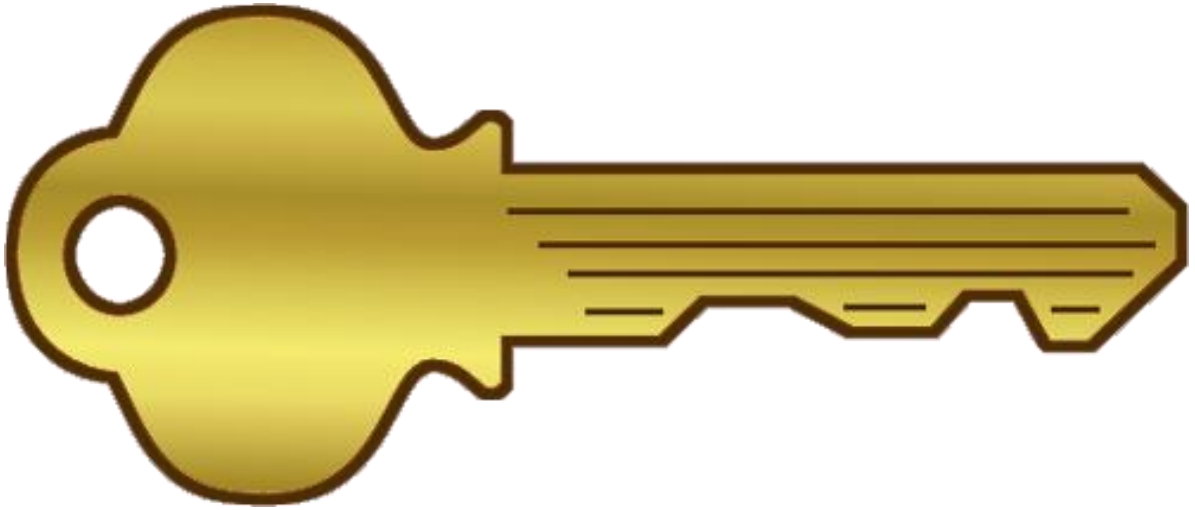
Your Commitment is a Key to Success



Committed Leaders Overcome All Barriers

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Implementing Perinatal Quality Improvement

www.perinatalQI.org

Conference on February 1, 2018, New York City


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Monet's Water Lilly Pond
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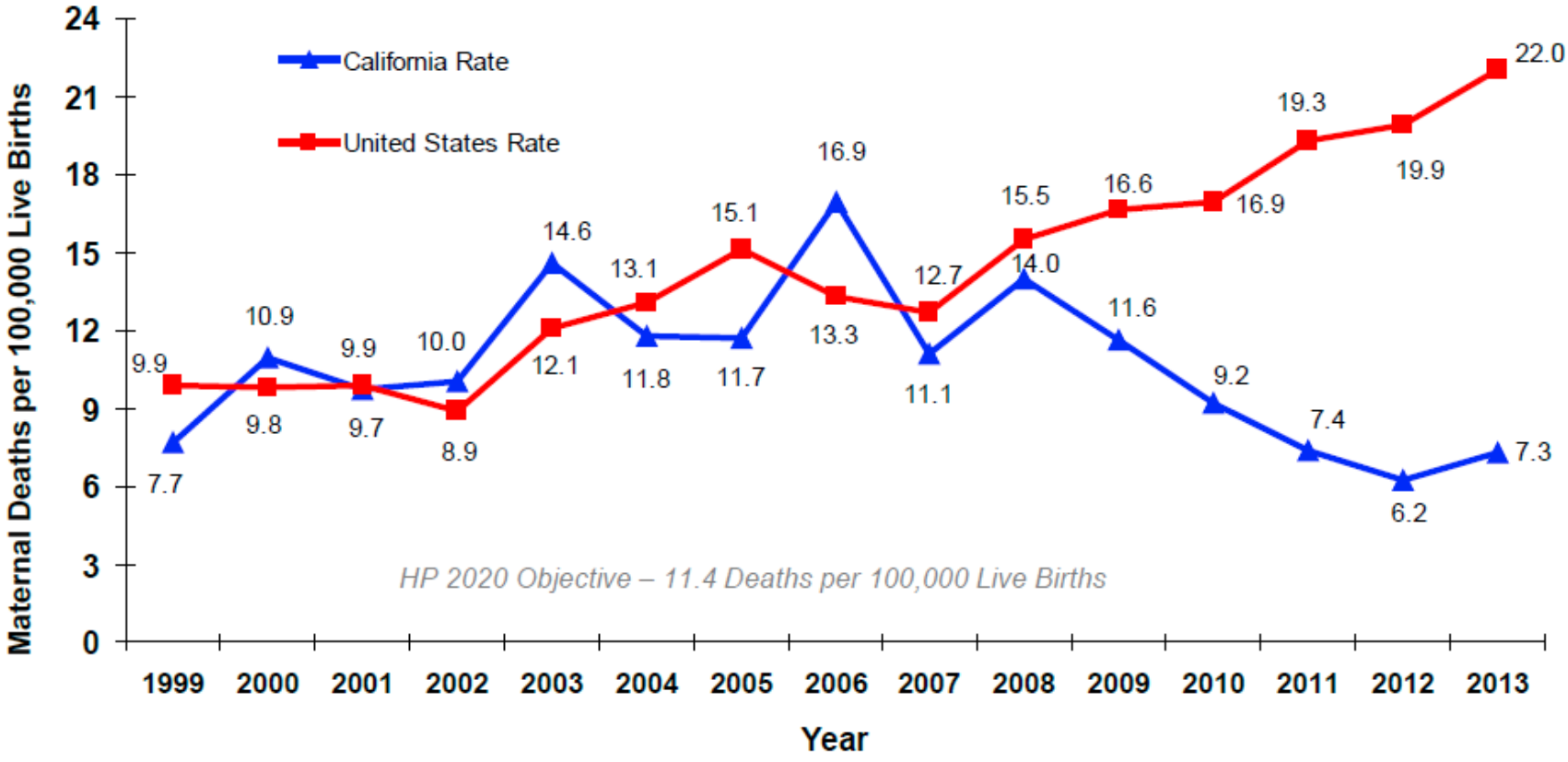
Maternal Mortality Rate, California and United States; 1999-2013



SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Maternal mortality for California (deaths ≤ 42 days postpartum) was calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99). United States data and HP2020 Objective use the same codes. U.S. maternal mortality data is published by the National Center for Health Statistics (NCHS) through 2007 only. U.S. maternal mortality rates from 2008 through 2013 were calculated using CDC Wonder Online Database, accessed at http://wonder.cdc.govon March 11, 2015. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, May, 2015.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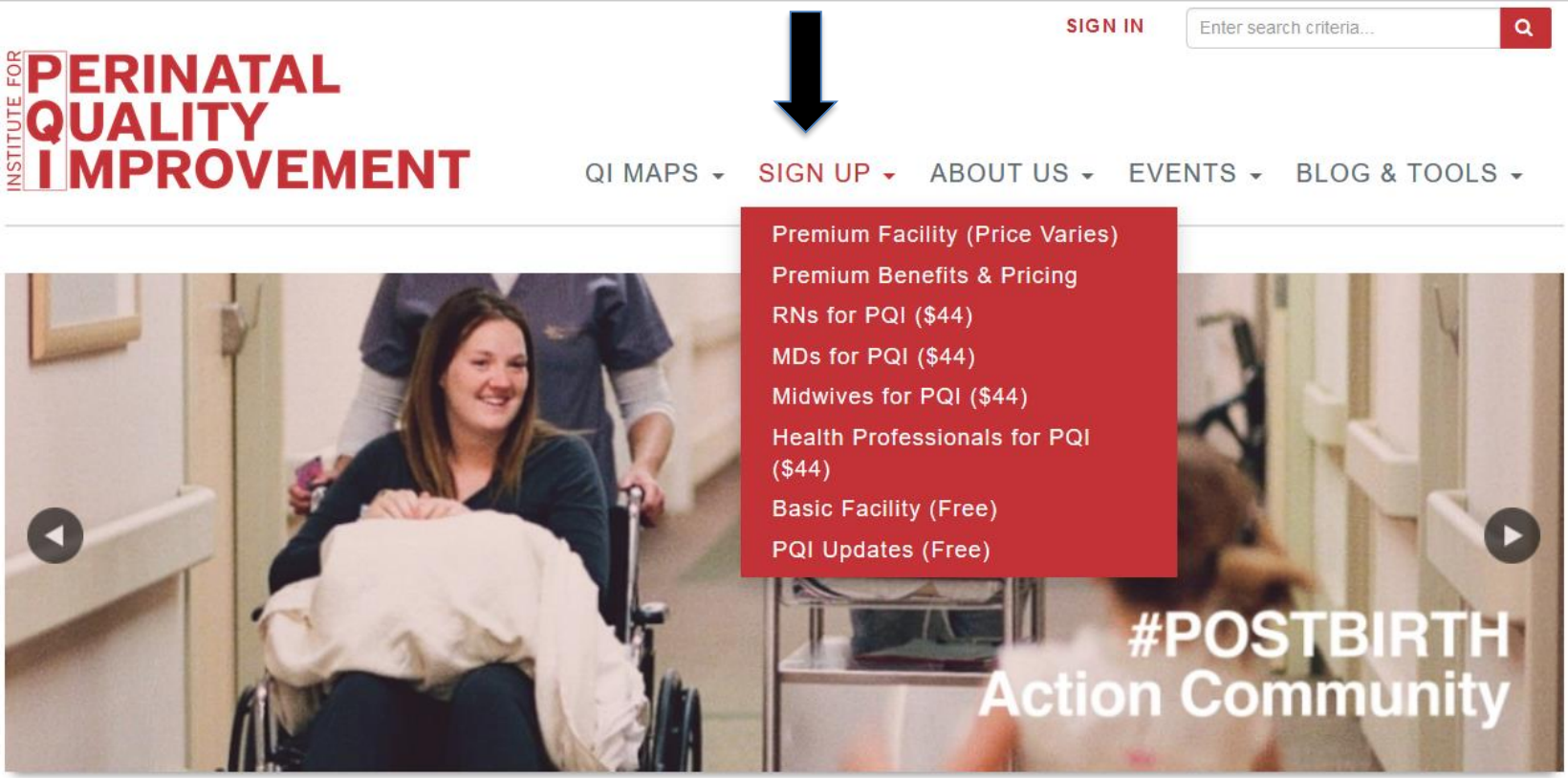

PQI Action Briefs Launch 11/30/17

1) Maternal and neonatal morbidity and mortality case study slide sets (2 per year)
2) Facilitator notes
3) Action Plan Templates with sample
   Fishbone Diagram, Driver Diagram, & Logic Model


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Questions?
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